Step by Step Guide to Anthem Blue Cross Enrollment Application

For members of the California Association of REALTORS®

Please complete the CA Real Estate License # and Requested Effective Date at the top of the form

Section A – Application Type (page 1)

- During Open Enrollment you should mark "Open Enrollment" unless you are a new member enrolling within the first 60 days of joining, or have experienced a Qualifying Event.
- Outside of Open Enrollment, applicants will mark either "New Enrollment" or "Qualifying Event"

Section B – Employee/Member Information (page 1)

- Fill in your personal information and provide your email address. We will frequently communicate with you via email so your email address is important.
- Employer name and address is required ONLY if you are a W-2 Employee of a C.A.R. member. If you are a W-2 employee of a C.A.R. member you are required to provide your employer's name, your hire date, your first date of full-time employment and the number of hours you work per week.
- **If you are a C.A.R. Member you should indicate the employer as "C.A.R." and provide your C.A.R. Join Date in the space provided for Hire Date.**

Section C – Type of Coverage (page 2)

C.A.R. has many preferred plans and they are indicated in the drop down box if you are completing this application in a PDF document.

- Select the medical plan name from the drop down in the fillable pdf.
- Next to the plan name, write in the "Contract Code" if you know it. (A 4 digit plan code shown on quotes)
- **Choose an option from the "Member Medical Coverage" section. Select a box to indicate whether you are enrolling alone or with dependents.**

Section D – Family Information (page 3)

- **EVERY APPLICANT MUST COMPLETE THE FIRST BOX WITH THEIR PERSONAL INFORMATION**
- If you are enrolling a Spouse or Domestic Partner or dependent children, you must provide their personal information in the spaces provided. **If you are using this form to add or drop dependents, select the appropriate box next to their personal information.**
- **If enrolling in an HMO Plan: Complete the "PCP Name" and "PCP ID No." to designate the Primary Care Physician for each family member. The PCP ID No. can be found by looking up your doctor on the Anthem website. Visit: www.Anthem.com/ca and click on "Find Care." Choose "Select a plan for basic search" and answer the appropriate questions. Be sure to select "Blue Cross HMO (CA Care) – Small Group" as the network.**

Sections E – Prior and Other Group Coverage (page 4)

- Provide information for any other coverage you or your dependents will keep in addition to the plan you are applying for. This information is particularly important to ensure smooth claims processing. Claims can be delayed if this information is not completed.
- **Be sure to answer all four questions in this section.**

Section F – Waiver/Declining Coverage (page 4)

You must complete this section **ONLY IF YOU ARE NOT ENROLLING YOUR ELIGIBLE SPOUSE/DOMESTIC PARTNER OR DEPENDENT CHILD** on the medical plan at this time.

- Check the box(es) to indicate who you are waiving/declining coverage for and indicate the reason you are declining coverage.
- List the names of the dependents that are not enrolling.
- Sign and date the bottom of this page **ONLY if you are waiving/declining medical coverage for a family member**.

Section G – Terms, Conditions and Authorizations (pages 5 & 6)

- Read this section and **sign and date the bottom of page 6**. Your application must be signed in order for us to process it.

If you have questions, please contact us at (800) 939-8088

Submit Completed Application WITH Initial Payment

- As a check, mailed with application
- Via Automatic Premium Payment, using the form below
- Via ACH or Credit Card through **ePay**
    - This link is only for C.A.R. medical, dental and vision plans or C.A.R. life and AD&D insurance. Do not make payments using this link for any other policies you may have with RealCare Insurance Marketing, Inc.
    - EPayPolicy will assess a transaction fee of 3.25% of the amount charged to the credit card or a $3.00 transaction fee per ACH payment. Transaction fees assessed by ePayPolicy will not be refunded.
    - Acceptance of payment by ePay is not a guarantee of coverage

Make your check payable to: RealCare Insurance Trust Account (R.I.T.A.)

Email Completed Forms To: RC-Enrollment@NFP.com

Or

Fax to: (707) 939-8450

Mail To:
548 Market St. PMB 91266
San Francisco, CA 94104

California Employee Enrollment Application For Small Groups Medical, Dental, and Vision

Use this form to:
* Enroll or Change Coverage
* Add/Drop Dependents

Anthem

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Submit application to your employer.

Please complete in black ink only.

Group/Case no. (if known)

CA Real Estate License #:

Requested Effective Date:

Section A: Application Type — select one.

☐ New enrollment ☐ Open enrollment ☐ Qualifying event
☐ COBRA/Cal-COBRA ☐ Rehire date (MM/DD/YYYY)

If you select **Qualifying event or COBRA/Cal-COBRA**, please select one event reason.

☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage — please explain (required): _____
☐ Other — please explain (required): _____

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY):

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address – (P.O. Box not acceptable unless rural address)	City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Employment status ☐ Full-time ☐ Part-time	Primary phone no

Employer name

Employee's physical work address (required)	City	State	ZIP code

Date of hire[2] (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins[2] (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog
☐ Other – please specify: _____

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Employee email address: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 If your employer imposes an orientation period for new hires, the "date of hire" is the first day after completion of the orientation period.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Section C: Type of Coverage — Your employer will advise you of your plan options and contract codes.

1. Medical Coverage	
Please Note: All health plans[2] include the required coverage for the dental and vision pediatric essential health benefits.	
Medical plan name[3]: **SELECT ONE**	Contract code, if known:
Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 These plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.

Social Security no.[1] _____

Section D: Family Information —

Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.

Please access *Find Care* at anthem.com/ca to determine if your physician is a participating provider. For HMO plans: provide 3- or 6- digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, children for whom you've assumed a parent-child relationship[2] (not including foster children) or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally incapacitating injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee Last name	First name	M.I.
Sex ☐ Male ☐ Female		Birthdate (MM/DD/YYYY)
Primary Care Physician (PCP) name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No
Primary Care Dentist (PCD) name (If selecting Dental Net DHMO plan)	PCD ID no	Existing patient ☐ Yes ☐ No

Add ○ Drop ○

Spouse/Domestic Partner Last name	First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)		Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name (if selecting an HMO[3] plan)	PCP ID no.		Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental Net DHMO plan)	PCD ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Add ○ Drop ○

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)		Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____
PCP name (if selecting an HMO[3] plan)	PCP ID no.		Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental Net DHMO plan)	PCD ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Add ○ Drop ○

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)		Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____
PCP name (if selecting an HMO[3] plan)	PCP ID no		Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental Net DHMO plan)	PCD ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 As defined in 2 CCR § 599.500(o).
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 Eligibility subject to Evidence of Coverage

Social Security no.[1] _____

Section E: Prior and Other Group Coverage

1. Is anyone applying for coverage currently enrolled in Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)
Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of Person covered (Last name, First, M.I.)	Type (select one)	Coverage (select all that apply)	Carrier name.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start End

Section F: Waiver/Declining Coverage — Proof of coverage will be required.

Type of coverage/Declined for: Select all that apply.		**Reason for declining/refusing coverage:** Select all that apply.
☐ Employee	☐ Medical	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: _____ ☐ Other — please explain: _____
☐ Spouse/ Domestic Partner	☐ Medical	
☐ Dependents	☐ Medical List name of dependents to be waived: _____	

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer, or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, OR VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, OR VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL VISION, PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/ Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the California Department of Managed Health Care that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event

Sign here only if you are declining coverage. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE

Signature of Applicant X	Printed name	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Social Security no.[1] _____

Section G: Electronic Delivery of Materials.

Employee email address: _____

For **Medical** and all **Dental Net DHMO** plans offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.

I am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical necessity determination notifications, Explanation of Benefits, other required notices and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools and I will make sure Anthem has my most up-to-date email address. I and my enrolled dependents understand that we can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

Dental & Vision not applicable to C.A.R. plans

For **Dental PPO** and **Vision** plans offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance. Anthem will deliver plan materials and related items by mail.

☐ By signing below, I and my enrolled dependents want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage, Evidence of Coverage, appeals, and medical necessity determination notifications, Explanation of Benefits, other legally required notices, and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I understand that this consent is voluntary and that I and my enrolled dependents can opt out of electronic delivery at any time. We can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

Applicant signature _____ Date_____

Section H: Terms, Conditions and Authorizations — Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. To the best of my knowledge or belief, all statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application or sold case coverage documents.

I understand that, to the extent allowed by law, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I understand that coverages will become effective on the date established by the provisions of the group policy, contract and certificates issued thereunder.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and myself.

By providing a phone number, I agree and consent that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem Blue Cross with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross with information regarding my HSA and that I may provide Anthem Blue Cross with a written request to revoke my authorization at any time.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Social Security no.[1] _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Read carefully — Signature required

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law.
By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

APPLICATION CHECKLIST

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Submit initial month's premium payment **(even if you are selecting the Automatic Premium Payment option)**. Include premiums/fees for all applicable insurance plans (medical, dental, vision, and life insurance).

  If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application.** After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose check for your first premium payment PLUS **a voided check or bank document with routing/account numbers.** Complete the form below and return to RealCare with your initial premium check**.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088

Submit Completed Application:
Mail To:
548 Market St., PMB 91266
San Francisco, CA 94104

Fax To: 707) 939-8450

Email to: Rc-Enrollment@nfp.com

Submit Initial Payment:
- ✓ As a check, mailed with application
- ✓ Via Automatic Premium Payment, using the form below
- ✓ Via ACH or Credit Card through ePay
  - This link is only for C.A.R. medical, dental and vision plans or C.A.R. life and AD&D insurance. Do not make payments using this link for any other policies you may have with RealCare Insurance Marketing, Inc.
  - ePayPolicy will assess a transaction fee of 3.25% of the amount charged to the credit card or a $3.00 transaction fee per ACH payment. Transaction fees assessed by ePayPolicy will not be refunded.
  - Acceptance of payment by ePay is not a guarantee of coverage

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that RealCare shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month prior to the month of coverage. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the first of the month of coverage. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: _____

Phone: _____ Email Address: _____

Banking Information

Name of Bank or Financial Institution: _____ ☐ Checking Account

Name on Bank Account: _____ ☐ Savings Account

Bank Routing Number: _____ Account Number: _____

Authorized Signature

_____ Date:_____

Signature of Authorized Signer on Above Bank Account
(As it appears in the financial institution's records)

Get help in your language

Language Assistance Services
Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نمی‌توانید، ما می‌توانیم از شخصی بخواهیم در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به صورت کتبی و به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً فوراً با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

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We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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